Navy Medicine

March-April 2009

NAVY MEDICINE

Official Publication of the U.S. Navy Medical Department
Volume 100, No. 2
March-April 2009

We Want Your Opinion

Letters to the Editor are welcome. Let us know what you think about *Navy Medicine*. Please send letters to: Janice Marie Hores, Managing Editor, Bureau of Medicine and Surgery, Bldg 1, Rm 1217, 2300 E Street, NW, Washington, DC, 20372-5300 or Janice.Hores@med.navy.mil or 19native47@verizon.net

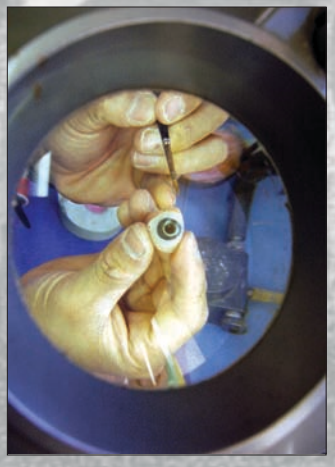
Navy Medicine, (ISSN 0895-8211 USPS 316-070) is published bimonthly by the Department of the Navy, Bureau of Medicine and Surgery, Washington, DC 20372-5300. Periodical postage paid at Washington, DC.

POSTMASTER: Send address changes to *Navy Medicine*, Bureau of Medicine and Surgery, ATTN: MANAGING EDITOR, Communications Directorate, Bldg 2, Rm 1217, 2300 E Street NW, Washington, DC 20372-5300.

Personal subscription address changes: write to *Navy Medicine*, Bureau of Medicine and Surgery, ATTN: MANAGING EDITOR, Communications Directorate, Bldg 2, Rm 1217, 2300 E Street NW, Washington, DC 20372-5300. Or email Janice.Hores@med.navy.mil or 19native47@verizon.net. Include old and new addresses when submitting a change of address to the above.

The Secretary of the Navy has determined that this publication is necessary in the transaction of business as required by law. *Navy Medicine* is published from appropriated funds by authority of the Bureau of Medicine and Surgery in accordance with Navy Publications and Printing Regulations P-35.

Online issue of *Navy Medicine* can be found at:
http://navyhistory.med.navy.mil/Publications/NavyMedicineMagazine.html



COVER: HM2 Daniel Cortez, an NMCSD maxillofacial prosthetics laboratory technician, applies a red fiber to a prosthetic eye to simulate a vein. Maxillofacial prosthetic technicians create prosthetics involving the cranium, such as custom teeth, eyes, ears, and facial bones, to minimize the appearance of congenital or acquired disfigurations. Story on page 24. Photo by MC3 Jake Berenguer, USN.

Contents

Articles and Book Review Submissions

Navy Medicine considers for publication photo essays, artwork, and manuscripts on research, history, unusual experiences, opinions, editorials, and professional matters. Contributions are suitable for consideration by *Navy Medicine* if they represent original material, have cleared internal security review, and received chain of command approval. An author need not be a member of the Navy to submit articles for consideration. For guidelines on submission, please contact: Janice Marie Hores, Managing Editor, Janice.Hores@med.navy.mil or 19native47@verizon.net

Navy Medicine is also looking for book reviews. If you've read a good book dealing with military (Navy) medicine and would like to write a review, the guidelines are:

•Book reviews should be 600 words or less.

•Introductory paragraph must contain: Title, author, publisher, publisher address. Year published. Number of pages.

•Reviewer ID: sample:

CAPT XYZ is Head of Internal Medicine at Naval Medical Center San Diego.

SAVE A TREE

If you would like to receive your issue electronically via email in PDF format, please contact Janice Marie Hores, Managing Editor, at Janice.Hores@med.navy.mil or 19native47@verizon.net

DIVERSITY

Because people are Navy medicine's most valuable asset, I am committed to the goal of maintaining the right workforce to deliver medical capabilities across the full range of military operations. We will achieve this goal through the appropriate mix of accession, retention, education, and training incentives.

If Navy medicine is to be fully successful, we must constantly strive to attract and retain the best people from all walks of life. If we expect to keep the talent we recruit, we must communicate and embrace the concepts of diversity to meet the professional aspirations of all our personnel. Diversity must become part of the everyday culture of our organization. We must continue to create an environment to attract the highest level of healthcare professionals by providing appealing job incentives, meaningful and challenging assignments, opportunities for professional growth, advanced educational and research opportunities, and options for family stability, and a long term career.

To that end, we have become a role model of diversity because we have focused on aligning ethnic and gender representation throughout the ranks to reflect our great nation's population. We have had many successes since our inception, including the establishment of the Nurse Corps (all women) in 1908, and most recently honoring me with the appointment of the Navy's first African-American Surgeon General.

Not only are we setting the example of a diverse, robust, innovative, and dedicated healthcare workforce, but this diversity also reflects the people for whom we care. As the medical providers for the warfighters of our great nation, we answer the call to provide medical care to our sailors, Marines, soldiers, airmen, and members of the Coast Guard. On the homefront and overseas, we also take care of their families, our retirees, and our personnel. Whenever and wherever the injured and ill call to us for medical care, we will be there to take care of them.

Navy medicine's diversity program promotes the message that we are the employer of choice for those individuals committed to a culturally competent healthcare organization. We offer a high quality work-life environment where our diverse workforce sees themselves represented at all levels of leadership.

Our leaders support professional environments promoting inclusion, inviting different points of view, embracing unique individual perspectives, enhancing the potential for personal and professional growth, and encouraging the contributions of all personnel. This is not just the job of Navy medicine leadership, it is incumbent on every member of the Navy medicine workforce to contribute to mission success.

We should all actively foster work environments where people are valued, respected, and provided the opportunity to reach their full personal and professional potential. This is my responsibility and your responsibility, and we all must take ownership of what we do to cultivate a diverse Navy medicine team.

We will continue to nurture diversity by:

Outreach - Leadership's educational and community outreach efforts embrace a wide variety of groups to stimulate an interest in careers with us.

Recruitment - We must all work together as a group to multiply our effectiveness in recruiting the best and brightest to our ranks. It is important that we continue to work with the Navy Recruiting Command, Bureau of Medicine and Surgery corps recruiters, the Uniformed Services University of Health Sciences, and the Navy Diversity Directorate (N134) in this initiative. In order for people to learn about and become excited about Navy medicine, we must go out to their communities and engage with them.

Mentoring - Leadership is responsible for developing the next cadres of diverse senior leaders throughout all corps. We need to support and expand mentoring opportunities and create mentoring environments, beginning with the Surgeon General and cascading throughout the chain of command.

Retention - It is important to expand opportunities for our personnel. One way is through post-graduate and continuing education. Another way is to adopt work-life balance policies that meet the organization's needs as well as those of our personnel.

Recognizing the shifting demographic population, growing competition among the military services and corporate America for talented personnel, tactical challenges such as force restructuring and joint operational mission, our diversity program's goal is to ensure we attract, develop, and retain individuals whose contributions are valued, respected, and who have the right skills to allow our organization to meet the dual mission of Force Health Protection and taking care of our beneficiaries.

VADM Adam Robinson, Jr.

Chief Of Naval Operations Diversity Policy

Diversity has made our nation and Navy stronger. To derive the most from that diversity, every individual, military or civilian, must be encouraged and enabled to reach his or her full potential. They must be inspired and empowered to attain the most senior levels of leadership. That empowerment today is unleashed by involved, thoughtful, proactive, and enlightened leaders. As leaders, we are all entrusted with the duty and responsibility to set and live the example by creating an environment where every individual's contribution is valued and respected. Future empowerment is cultivated by that same leadership and mentorship and an active commitment to attracting and recruiting the very best. We will foster an environment that respects the individual's worth based on his or her performance regardless of race, gender, or creed.

As the Chief of Naval Operations, I will lead diversity initiatives in the Navy. I challenge all who serve to do the same through leadership, mentorship, service, and example. Our involved, proactive leadership will create and enable an environment and a Total Workforce that values uniqueness, different perspectives, and talent. Workforce character and professionalism is a priority in our Navy. Accordingly, we will support a culture of professional and personal development, ensuring our people are trained and educated to accomplish our mission, with opportunities available to all in an equal manner.

We must not be locked in time. As leaders, we must anticipate and embrace the demographic changes of tomorrow, and build a Navy that always reflects our country's make up. We must lead in ways that will continue to draw men and women to service to our country and to our Navy. Diversity of thoughts, ideas, and competencies of our people, keeps our Navy strong, and empowers the protection of the very freedoms and opportunities we enjoy each and every day. The vast talent, diversity, and experience of our citizens will continue to be our strength, and will ensure our Navy's relevance and our nation's security and prosperity.

As we enhance and empower our diversity, we will remain a global force for peace, and epitomize the ideals that make our Navy great and our nation the best hope of freedom. We will sustain our force through the fair, equal, and ethical treatment of every member of the United States Navy.

–G. Roughead, Admiral, U.S. Navy

CNO Releases Diversity Podcast

The Chief of Naval Operations (CNO) ADM Gary Roughead released a podcast on the importance of diversity and the Navy's diversity initiatives 27 February 2009.

In the podcast, Roughead talks about the strides the Navy has made since he released his new diversity policy in 2008. He emphasized that a diverse population is important because when sailors and Navy civilians are approached with issues, it provides a range of ideas, perspectives, and backgrounds that provide better solutions making the Navy stronger,

"In the military and in the Navy, it's important that we are a diverse organization because we have to represent what I call the face of America," said Roughead. "As our population changes and the percentages of majority-minority changes, and that's always taking place, we have to reflect that same demographic in our Navy and that's why it's important. However, at the end of the day, it really makes a huge difference because we're stronger because of the different perspectives and ideas that people bring to bear."

CNO also said the diversity of the Navy has made great progress in recent years.

"We've expanded our junior ROTC programs, we're expanding our ROTC programs, we're offering scholarship opportunities sooner than we did before so that the young men and women can make an earlier choice," he said.

He expressed that it is each individual's responsibility to recruit, develop, educate, and retain leaders from and for all parts of the Navy and nation.

"Diversity is also about leadership and looking for young men and women with talent and drive and competence and putting them in positions where they can succeed," said Roughead.

He stressed the value of a diverse Navy and the success it will bring the young men and women put in positions to lead sailors in the future.

"Those positions then enable them to reach higher and go further in the Navy then they would have had they not had a leader who was looking out for them, mentoring them, training them, and guiding them along in a career that is the best in the world," Roughead said.

To listen to the podcast, visit www.navy.mil/navydata/cnoPlay.asp?id=3078

–Chief of Naval Operations Public Affairs.

Tuskegee Airman Kicks Off Black History Month at NMCP

Three Tuskegee Airmen, fresh from attending the inauguration of President Barack Obama, came to Naval Medical Center Portsmouth 3 February to help the hospital kick off Black History Month.

One of the airmen, 88-year-old Grant S. Williams, Sr., of Hampton, was the featured speaker. He rose to the rank of Chief Master Sergeant and got his start in the military serving in administrative positions in the Tuskegee Airmen, the first black airmen in the U.S. military. A recipient of two Bronze Stars for meritorious service in Italy in World War II and in Vietnam, he served nearly 30 years in the military from 1942 to 1945 and from 1950 to 1975, when he retired at Langley Air Force Base.

Williams spoke of having to prove himself during a time when the South was segregated and black men were not offered the opportunity to excel in the military. The all-black Tuskegee Airmen were formed in 1941 at Tuskegee Institute. They trained at an all-black airfield in Tuskegee, AL. The airmen were active during World War II and continued to train until 1946. Williams said, because of bigotry, "We had to fight for the right to fight for our country. The performance of this organization led to the integration of the military," he added.

Looking back on his accomplishments, Williams left with some advice for young people. "If you put your mind to do it, you can do it. It can be done."

He echoed his own words when he spoke about attending the Presidential Inauguration, calling it, "Awesome, it was the thrill of a lifetime."

Tuskegee Airmen

The Tuskegee Airmen flew as four separate squadrons which were later combined to form the all-black 332nd Fighter Group of the U.S. Army Air Corps (later the U.S. Air Force).

By the end of World War II, the Tuskegee Airmen were credited with 109 Luftwaffe aircraft shot down, the German-operated Italian destroyer TA-23 sunk by machine-gun fire, and destruction of numerous fuel dumps, trucks, and trains. The squadrons of the 332nd flew more than 15,000 sorties on 1,500 missions.

In all, 992 pilots were trained in Tuskegee from 1940 to 1946; about 445 deployed overseas, and 150 airmen lost their lives in accidents or combat.

Two years ago, Williams was among approximately 350 airmen and their widows who were collectively awarded the Congressional Medal of Honor.

Deputy Commander CAPT Craig Bonnema presents a Letter of Appreciation to CMSGT Grant Williams, USA (Ret.) after speaking to hospital staff about his experiences as one of the Tuskegee Airmen. Photo by MC2 William Heimbuch, USN

HM2 Y'Eishia Hopkins appreciated Williams' words. "Times have changed so drastically in the last century, with many people not knowing their history anymore. If you don't know where you came from how are you going to know where you're going."

The event was designed for all staff, not only for African Americans. "It is also to create interaction in our diverse culture," said HMC Albino DeCastro. "We thrive on the diversity of our people which give us the diverse ideas, creativity, philosophies, and ideologies that create a synergistic environment giving us a very dynamic society the likes of which is seen nowhere else in this world. That is 'America the Beautiful.'"

The kickoff also included I.C. Norcom High School NJROTC and Jazz Combo, step performances by Zeta Phi Beta and Kappa Alpha Psi, followed shortly thereafter by the National Anthem by HMC Jason Patterson and remarks by Deputy Commander CAPT Craig Bonnema. WTKR-TV's Domonique Benn served as emcee.

As the event concluded, Hopkins said it "left everyone with a renewed sense of pride and respect for all who have gone before us to get us to where we are today."

–Story by Deborah Kallgren, NMCP Public Affairs.

Master Chief Leads Way for Sailors, Women

A senior enlisted—female—leader has been praised for the inspirational leadership and insightful mentorship she provides sailors; she embraces diversity and encourages all sailors to look beyond gender and focus on the contributions each one makes to mission accomplishment.

CMC(SW/AW) Kathleen A. Hansen stationed at the Naval Medical Center San Diego (NMCSD) leads 1,500 sailors.

"It's the first time that I've ever had a female CMC," said HMC Medea Dudley, a NMCSD chief.

"The leadership is still the same. The mentorship is still the same. The job is still the same. I think her job is much bigger than any other CMC's job that I've ever worked with because she's got Medicine West and [the Naval Medical Center], and she's doing a phenomenal job in my opinion."

Hansen says she relishes the role of mentor and is grateful to the leaders she looked up to in the past. She fully appreciates it all comes full circle.

"That's what keeps me doing this," said Hansen. "To see that I've been a positive influence on a sailor is a great feeling. I'm grateful for all the people who were a positive influence on me."

Acting as a mentor is a role that Hansen fills every day. "What women (in the Navy) need to understand is that when one of us is successful, we're all successful. We need to embrace each other's successes," she said.

In her own life, she has learned to look past a person being male or female.

"One day I was on a ship watching 20 people handle lines for a small boat," said Hansen. "I realized they were all women, and it was an amazing moment for me, having grown up in the Navy with mostly men."

As a female CMC, Hansen has been chosen to represent the Navy for many important occasions. One that holds personal significance for Hansen was the groundbreaking and dedication of the Women's Memorial in Washington.

"That day there were women veterans from WWII, and it was phenomenal," said Hansen, who has her picture on the memorial, along with three of her nieces who've also served in the Navy.

"The memorial preserves a living log and history that young women aren't interested in but some day may be. It keeps a living log and history of all of us."

Despite being prominently featured on the memorial, humility seems to be an inherent quality in the master chief. After being named one of San Diego's top 10 "Cool Women," a Girl Scout Leadership Award, Hansen was surprised to see herself taking the stage alongside other prestigious female leaders from around the county.

"It was funny standing on the stage," she sad. "They had all these doctors and lawyers and people that I was really in awe of—then me!"

Although she appreciates the significance of celebrating Women's History Month (March), Hansen thinks drawing attention to the fact that a person accomplishing something solely because they are female can be discouraging.

"It's the year 2009 and the fact that we're still saying women are the first at something is sad to me," she said.

When people remember her life and career, Hansen hopes that the fact she is female is not a defining characteristic of her successes.

"In the end, I don't want people to say that 'she was a good female CMC,'" said Hansen.

"In the end, that shouldn't matter. I just want people to say that 'she was a good command master chief.'"

For more news from Navy Region Southwest, visit www.navy.mil/local/cnrsw/

–Story by Emily Butcher, Commander Navy Region Southwest Public Affairs.

NHB Diversity Council hosts Black History Month Celebration

In recognition of Black History Month, Naval Hospital Bremerton's (NHB) Diversity Council hosted a celebration for all staff members and eligible beneficiaries on 27 February 2009. The event featured guest speaker Eva Abram, a historical storyteller who presented a dramatic portrayal of Rosa Parks entitled "Civil Rights: A History of Us."

"This was our first time in bringing in a speaker and someone from outside our command," explained YN2 Sandra Navarrete, Naval Branch Health Clinic Bangor and NHB Diversity Council member. "But every year we have a different theme and then try to bring awareness to that theme. This year our focus is 'we are the change we seek,' and we thought having Eva Abram here would make the event even more relevant."

Abram immediately took on the noted personality of Mrs. Rosa Parks after being introduced. Through the portrayal of Parks, she recalled the turmoil and struggle of the times regarding the Montgomery bus boycott and what it felt like to live as a second-class citizen. Her well-researched dramatic portrayal brought to light one of the most pivotal events concerning the fledgling civil rights movement in American history.

"When we look back, some say, 'what was the big deal?'" Abram said. "I tell younger people that what Rosa Parks did was just one small step. People had to struggle for everything during that time. It was a major accomplishment."

Eva Abram, originally from New Orleans, has lived in Seattle for more than 30 years. She began training as a storyteller in 2000, after identifying storytelling as a wonderful way to share historical and cultural information in an accept-

Eva Abram, gives a stirring portrayal of Rosa Parks in her "Civil Rights: A History of Us." Photo by Douglas H. Stutz

able, non-threatening way to people of all ages. She researches, writes, and presents stories of American history and multicultural folktales to enhance school, museum, and library programs.

According to Navarrete, the Diversity Council gets together well before a specific month to brainstorm on how to proceed with honoring and recognizing the upcoming designated historical month. "We always try to do something we haven't done before," said Navarrete. "Our goals are the same in every event; to bring awareness and present an educational program. We try to make our presentations relevant. We want people to enjoy what we do. Having Eva Abram as guest speaker was one option that we knew would be well-received."

The Diversity Council's programs have all received enthusiast support from staff members and assembled audiences. They are known for being fun, entertaining, and instructional. Yet the audience doesn't see the long hours and dedicated work of preparation that goes into every performance. "It is a lot of work to put on a really good cultural exhibition," Navarrete said. "We get together after work and on the weekends sometimes for up to 4 hours. We have a devoted group who are always trying to do their best."

Once the actual event starts, all the hours leading up to it are forgotten. Performances like Abram's take on their own momentum. Audiences get transfixed. Passersby slow, and then completely stop to bear witness. Navarrete attests that's when she knows all the work beforehand that went into the event has been worth the effort. "It's fun to look out in the audiences and know they appreciate what we're doing and that we got our message across," said Navarrete.

–Story by Douglas H. Stutz, NHB Public Affairs.

LETTERS TO THE EDITOR

To Whom It May Concern:

In your January-February 2009 edition of the *Navy Medicine* magazine, page 12 has two awards listed with their acknowledgments for their award. After reading what HM1(FMF/SW) Wheeler did while he was deployed to earn such a prestigious award, it made me very proud to be a Fleet Marine Force Corpsman. He did an outstanding job under fire and is very deserving of his award. There are many people who owe their life to him because of it.

Below HM1 Wheeler is LCDR Hoekman who received a Bronze Star for what the write-up describes as doing his job. Not to discredit the good LCDR, but the Bronze star for doing a job well done in his case should not be the prestigious Bronze Star.

The requirements for the Bronze Star reads:

"To justify this decoration, accomplishment or performance of duty above that normally expected, and sufficient to distinguish the individual among those performing comparable duties, is required, although less than the requirements for the Silver Star or the Legion of Merit. Minor acts of heroism in actual combat, single acts of merit or meritorious service connection with military or naval operations may justify this award."

I really think that the values of our awards are being diminished because of the interpretation of the requirements. This is not to say that LCDR Hoekman does not deserve an award, but in my opinion it should not be a Bronze Star. HM1 Wheeler should have received the Bronze Star with the combat distinguishing device.

–HM1(FMF) Tommy Childress, USN

Caregivers Learn to Take Care of Self

The business of medical care professionals is caring for others. Often overlooked is care for the caregivers themselves. Particularly those who serve in intense situations like disasters and battlefields. The Navy Medicine Caregiver Occupational Stress Control (OSC) program training team recently provided stress management training to approximately 90 Navy medical caregivers from around the world at San Diego.

Informally known as Care for the Caregiver, the training focused on understanding occupational and compassion fatigue, caregiver stress, and burnout. Left unrecognized, accumulated stressors could lead to medical errors, job dissatisfaction, and poor retention.

"The goal is that we have 80-90 people that have some new skills and some new training, and the training will provide them a new insight into work that they can do in their own command and support that they can provide to others," said RADM Karen Flaherty, Deputy Chief, Wounded, Ill and Injured. "Part of that is making sure that there is a self awareness of your own health, that there are things that you can do personally to improve your overall health, and as a result the support we can provide to the wounded is better."

The Caregiver OSC program focuses on three fundamental principles: early recognition, peer intervention, and connection with services as needed, according to CAPT Richard Westphal, mental health clinical specialist at the Navy's Bureau of Medicine and Surgery in Washington, DC, and designer of the caregiver program.

Westphal said no matter what their role, sailors need to recognize early warning signs of distress and intervene. The goal is to provide caregiver intervention and resources before pressure have impaired the individual's ability to be effective.

Topics covered during the conference included buddy care assessment and intervention, self care, compassion fatigue skills, and work environment assessment.

"This is tied to the Commandant of the Marine Corps, the Chief of Naval Operations, and the Secretary of the Navy's initiatives to do what is right for all of our sailors and Marines, and part of what we're doing is figuring out how to do right by our caregivers," said Westphal.

Several tools presented by Westphal include After Action Reviews, Combat and Operational Stress First Aid, self modulation skills, core leader functions, a stress injury decision matrix and OSCAR communication. OSCAR communication consists of Observing behaviors, Stating the observations, Clarifying role and your concern about the behavior, Ask why to seek clarification of the behaviors and Respond with guided options.

After action review is a tool for small groups led at the unit level following a significant event. The reviews are for caregivers to understand what happened and why, anticipate and address problems particularly loss of confidence and excessive self-blame or over-confidence.

After action reviews provide an opportunity to assess the health and readiness of the unit and its members as well as support unit cohesion and reinforce shipmate and buddy dialog. After action reviews also create an opportunity for future healing if needed.

Combat and Operational Stress First Aid (COSFA) is similar to basic life support in that it combines assessment and getting help with effective actions. The seven C's for helping a shipmate Check, Coordinate, Cover, Calm, Connect, Competence, and Confidence:

- Check—look, listen, assess.
- Coordinate—get help, refer as needed.
- Cover—quickly get to physical or emotional safety.
- Calm—slow deep breaths, slow heart rate, begin to relax.
- Connect—get support from others.
- Competence—restore effectiveness.
- Confidence—restore trust in self, others, and mission.

Self modulation or Subjective Units of Disturbance Scale (SUDS) is a 0-10 scale for measuring the subjective intensity of distress.

Core leader functions are designed for leaders to strengthen the unit, identify stress loads and recognize reactions, injuries and illnesses; mitigate by ensuring adequate sleep and rest along with removing unnecessary stressors, treat through chaplains and medical services and finally, reintegrate a unit member who has been away.

The Operational Stress Control Decision Matrix is a flow chart with "yes" and "no" directions to help guide leaders and peers to assessing the potential severity of a sailor's stress levels. The four color chart begins with green for ready followed by a yellow zone as a flag for someone reacting. Upper zones are orange for injured followed by red to indicate medical intervention.

"We must interrupt the cycle of stress as early as possible," said Westphal. "If we do that for our shipmates then the need for high-end mental health services is reduced, we get a reduction in non-judicial punishments and a reduction in destructive behavior."

Westphal said he has had tremendous positive feedback from participants of the training.

"It's very helpful and I really appreciate this training," said HMC Straussi Mumford of Naval Hospital Camp Lejeune, NC. "This is information that I can take back to my command to help out."

Westphal and the rest of the Caregiver OSC program team members intend to follow up with each of the commands' represented at the conference within the next 6-8 months to conduct training for all personnel.

–*Story by MC2* Stephanie Tigner and MC1 Cindy Gill.

Lejeune Area Battles Healthcare Shortage

As Camp Lejeune continues to grow, so does the Naval Hospital. This year, hospital officials plan to hire 50 mental healthcare professionals and a neurologist while expanding pediatric services. And by 2013 the hospital will have a new wing, an additional 109,000 square feet that will include, among other things, a larger emergency department.

But the demand for services is much greater than the resources available on base and in the local community. And the problem is expected to get worse.

The hospital's growth is tied to the Corps' expansion to 202,000 Marines. By the end of 2011, 11,000 additional Marines, sailors, and defense contractors will reside in eastern North Carolina, home to Camp Lejeune, Marine Corps Air Station (MCAS) New River, and MCAS Cherry Point. Roughly half are already here.

Beyond the gates, where last year an average of 2,700 Tricare patients were referred for healthcare each month, there is a shortage of doctors and mental health providers, a trend seen nationwide.

The Naval Hospital has more than 140,000 potential beneficiaries, according to its commander, CAPT Gerard Cox. Of those, about 35,000 are enrolled at the hospital, and 35,000 are active duty service members who receive primary care from Navy medical personnel within each unit.

About 20,000 are enrolled in Tricare Prime and receive their healthcare outside the Naval Hospital and clinics. The rest are on other insurance plans, Cox said.

The influx of Marines and their dependents will only further the strain on off-base providers. And there is little relief in sight, unless the Defense Department acts to increase Tricare reimbursements, according to a preliminary study by North Carolina's Eastern Regional Military Growth Task Force.

"We have providers who are already overwhelmed because there is a local, regional, state, and national shortage" of physicians and mental healthcare providers, said Dr. Margaret Merrick, who chairs the task force's Medical, Health and Social Services Committee. "Their practices are full."

Merrick, a pediatrician who worked in a large group practice for 17 years, now works for A+ Medical Business Services, a consulting firm in Morehead City, NC.

Because Tricare reimbursement is low—about the equivalent of Medicaid and, in some cases, lower—many local physicians limit the number of Tricare patients they accept.

"We live here," she said. "This is our home. We kind of feel like it's our obligation to see these patients, but it has been very, very hard to make ends meet. They certainly couldn't make it if they only took Tricare patients. Most practices try to establish a patient mix."

For the patient, this means sometimes traveling outside their community for medical attention. Most people referred off-base do not stay within Onslow County, where Lejeune is located, Cox said. Each day, the Naval Hospital medevacs patients to larger hospitals such as New Hanover Regional Medical Center in Wilmington and Pitt County Memorial Hospital in Greenville. Wilmington, the closer of the two, is more than 50 miles from Lejeune.

The opposite is true for patients seeking mental health services. "Jacksonville is a bit of an anomaly in terms of the mental health providers they have," Merrick said.

The city has a high concentration of mental health providers, she said, noting Brynn Marr Hospital, which caters to patients with mental illness, chemical dependency, or developmental disabilities. "But, when you get out of Jacksonville itself, it's very slim pickings," Merrick said.

Cox said the wars in Iraq and Afghanistan have produced greater demand for mental health services. Last year, the hospital hired 15 mental health providers.

Most active-duty personnel at Lejeune and the air stations receive mental health services at the Naval Hospital. But each month about 140 Tricare patients, primarily dependents and retirees, are referred to mental health specialists in town, Cox said.

The only realistic solution to attracting more mental health professionals to the area is through a locality waiver from the Defense Department, Merrick said. These waivers increase the Tricare reimbursement rate. "I'm positive that eastern North Carolina would qualify," Merrick said. "I don't see any other way. What is the incentive for them to see our military and their dependents, when their reimbursement is going to be lower than all the other reimbursement plans?"

–Story by Trista Talton, Staff Writer, Marine Corps News.

Navy Revises Tracking of Sailors Health Post-Deployment

Commands may now access the Deployment Health Assessment (DHA) Program instruction online.

OPNAVINST6100.3 cements the requirements for periodic assessments prior to and after deployments.

"When leadership takes an active role in making sure that the assessments take place then we know we are really taking care of sailors physical and emotional needs," said Fleet Master Chief Mike McCalip, Office of the Chief of Naval Personnel.

"Sometimes sailors in a hurry to get demobilized or back to their pre-IA (individual augmentee) job may not spend the time on the post-deployment assessment that they should and issues arise months after a deployment. The post-deployment re-assessment (PDHRA) is designed to pick up those issues," he added.

Sailors frequently rate their overall general health worse 3-6 months after returning than they did immediately upon return. The process is designed to identify stress injuries and other health concerns that require further assessment or treatment.

Sailors are required to undergo a Pre-deployment Health Assessment (Pre-DHA), form DD 2795 no earlier than 60 days prior to the expected deployment date. Then when the sailor returns from deployment a Post-deployment Assessment (Post-DHA), form DD 2796 should be completed as close to their homecoming date as possible, not earlier than 30 days before the expected redeployment.

Reserve sailors should complete the Post-DHA before being released from active duty. The PDHRA form DD 2900 should be completed between 90 and 180 days after return from deployment.

To make life easier, Deployment Health Assessments are all submitted electronically by a nurse, corpsman, or medical technician. If a service member gives positive responses to some questions, the assessment may be bumped up for review by a physician, physician's assistant (PA), nurse practitioner (NP), or independent duty corpsman (IDC). The PDHRA can only be done by a physician, PA, NP, or IDC.

For more information on the assessments and reassessments review OPNAVINST 6100.3 available in the reference section on the Navy Personnel Command Website: http://www.npc.navy.mil/channels/

–Navy Personnel Command Public Affairs, Millington, TN.

CNP Wants Sailors to ACT to Prevent Suicide

The Chief of Naval Personnel spoke to sailors on the importance of suicide prevention, 11 February during a visit to Navy Personnel Command.

"It is an all-hands responsibility for shipmates to recognize when someone may be in distress. It is the responsibility of leadership to ensure the programs are in place and that sailors have access to them. It is the responsibility of chief petty officers and leaders on the deckplate to recognize when sailors are under stress and to ensure they have access to treatment programs," said VADM Mark Ferguson, USN, Chief of Naval Personnel.

LCDR Robert J. Hines, assigned to Pre-commissioning Unit *George H.W. Bush* (CVN-77), speaks to the crew during the command bi-annual safety stand down about dealing with a fellow sailor who may be a suicide risk. Sailors were also briefed on seatbelt use, eye protection, hearing conservation, and the dangers of driving under the influence of drugs or alcohol. Photo by MCSN Joel S. Kolodziejczak.

"Suicide is generally a response to stress, to a person feeling hopeless or distressed with their personal situation. It is a tragedy and one that can be prevented," said Ferguson adding that sailors may be able to help prevent suicide if they ACT (Ask-ask the person if they are thinking of hurting themselves, Care-listen and let the person know they are not alone, and Treatment-get your shipmate to help as quickly as possible; such as the duty officer, chaplain, friend, medical personnel, or others who can help.)

"If people remember to ACT, ask, care, treat, they will be on the right path," said LCDR Bonnie Chavez, behavioral health program manager for the Navy. Chavez recently introduced a series of suicide prevention posters designed by sailors to help teach sailors to ACT.

"Don't be afraid to ASK someone if they are thinking of taking their own life. CARE enough to let the person know that suicidal feelings are temporary and that depression can be treated and then get help. TREAT, take them to an emergency room or walk in clinic, don't leave them alone, take action, remove means, such as guns, stockpiled pills, ropes, and sharp objects," said Chavez.

Suicide prevention education is among the 12 general military training topics required for all hands in 2009. The new course titled Introduction to the Stress Response Continuum and Suicide Awareness is available at Navy Knowledge Online.

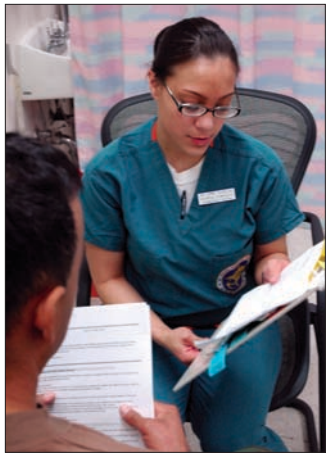
Commands can find more information about suicide prevention in OPNAVINST 1720.4, Suicide Prevention Program, which provides guidance for commanding officers and senior enlisted leadership on suicide prevention training.

Early intervention is vital to suicide prevention efforts at all levels of the Navy. Chavez pointed out that most people give some warning of their suicidal intentions to a friend or family member and that all suicide threats should be taken seriously.

To find out more information and to view a list of the warning signs, visit www.suicide.navy.mil

–Navy Personnel Command Public Affairs, Millington, TN.

NMCSD Implements Medication Reconciliation



HN April Casillas discusses a medication list and followup instructions prior to discharging a patient. Photo by MC3 Jake Berenguer, USN

Understanding medications and tracking multiple prescriptions can be a challenge for both patients and medical providers. Naval Medical Center San Diego (NMCSD) implemented a program to help patients understand their medications and assist providers by providing a clear picture of patients' medication regimen.

Medication reconciliation is an accurate list of prescriptions provided to the patient at the end of every appointment, according to CDR John S. Hammes, chairman, department of internal medicine, NMCSD.

"For each and every patient we see in the clinic, we are sure to ask them if they have had a chance to review the medication list provided to them by the front desk when they checked in," said NMCSD's head of internal medicine, CDR Alan Douglass. "I have noticed that most patients will not produce the list until I ask about it."

At NMCSD all members who are certified to prescribe medication are involved in the medication reconciliation process." Clerks and hospital corpsmen checking in patients, facilitate the process by generating a current list of medicines and present the list to the patient to review and note prescription conflictions that may be present. Some combinations of medications can cause serious reactions, so to prevent that, their provider reviews the list and makes corrections as needed.

If there is confusion, patients can contact the provider who prescribed the medication in question or their primary care giver. The patient is given an updated list at the conclusion of each appointment. For inpatients, a specific medication reconciliation worksheet is generated using the Electronic Medical Record, which tracks medications and provides an accurate discharge summary.

"It is important because inadequate or incomplete reconciliation results in patients taking too much, too little, the wrong type, or harmfully interacting drugs," said Hammes.

Lack of information about a patient's medication history can cause serious adverse effects. Implementation of medication reconciliation is a requirement for every accredited hospital in the United States. NMCSD is committed to ensuring that all patients receive safe, quality care, according to Hammes.

"It is a national goal to improve the use of prescription drugs. We require every patient who visits a clinic or ward to update the medications listed in their record. Their medication list will then be either added or removed from their medical record," said LT Laura Baraniak, NMCSD's senior nurse officer in the Medical Health Center. "Every patient should carry a list of all prescriptions and over the counter medications, herbals, and vitamins."

NMCSD has incorporated the medical reconciliation computer program in all clinics and support staff's computers according to Hammes.

"Since we began using the program we have cut down the time it takes to check-in and check-out a patient and it makes explaining the medications and precautions easier for them to understand," said dental assistant HM3 Michelle Sabino. "Before we had the program, patients often got lost in the medical lingo and acronyms, and that's exactly why this program was put into action. We want to know what they are taking, and we want to explain in detail what their medication does, track past prescriptions and determine if they are compatible."

The process was screened and adjusted over a period of 3 months through random patient selection. Approximately 100 patient encounters were evaluated according to the office of the Chief Medical Officer website (http://www.tricare.mil/OCMO/). Results showed patients leaving the internal medicine clinic with a clear and accurate understanding of their medication rose from 35 percent to 90 percent. All medication lists met the medical reconciliation standards set by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), and reduced waiting time by approximately five minutes per patient.

"We have been using the program here at NMCSD in internal medicine for about a month now and we are having great results. I really appreciate how dedicated my staff is to ensuring that they are diligent about this," said Douglass.

–Story by MC3 Jake Berenguer, USN.

NMSC hosts Vanguard 2009 Symposium

Sixty representatives from 29 Navy and Marine Corps commands throughout Navy medicine attended the Vanguard 2009 Symposium hosted by Navy Medicine Support Command (NMSC) and held at Naval Air Station Jacksonville, FL, 10-12 February 2009.

The symposium mission was to identify and prioritize the gaps in the capabiliies of Navy medicine, as well as requirements, and emergent needs for the next generation of Force Health Protection and expeditionary medicine. The mission was also to provide areas with needs for high-level investment strategy in support of BUMED's strategic goals and research for operational readiness, military healthcare, and health promotion.

RADM Richard Jeffries, addresses attendees at the Vanguard 2009 Symposium. Photo by MC1(SW) Arthur N. De La Cruz, USN

"Vanguard is looking at the future capabilities the Navy and Marine Corps team will need to meet the mission requirements of the future," said RADM Richard Jeffries, Medical Officer of the Marine Corps and symposium guest speaker. "And behind that is, 'What is the research that we need to start now to get the answers for that?'"

"This symposium is about looking toward the future and trying to invision what that end-state scenario should be, and then how do we get there. What can the research community bring forward that we can use to accomplish the goal?" Jeffries explained. "We're trying to identify those individual, as well as joint abilities that we need to pursue. And then, at the outbrief, we'll have the priorities identified and what we need to do to have the research community focus on getting solutions."

Dr. Keith Prusaczyk, Ph.D., is one who will use what he learns at Vanguard to help Jeffries and Navy medicine determine what the research community can bring forward. Prusaczyk is the Navy Medical Advance Development Program Director with the Naval Medical Research Center (NMRC) in Silver Spring, MD. He is also a strategic adviser and working group representative for RADM Richard C. Vinci, NMSC Commander, for the acquisition of Force Health Protection and future naval capabilities. NMSC has oversight of NMRC and Navy Medicine's Research and Development Program.

"The outcomes that we anticipate from this symposium are a set of initial capabilities that allow us to define warfighting gaps," said Prusaczyk, who manages the advanced development of the Surgeon General's Research Development Testing and Evaluation. "This symposium allows us to prioritize our investments. Right now we have a portfolio that addresses both battlefield medicine and clinical MTF (medical treatment facility) medicine. What we have to do with limited resources is balance that portfolio to meet warfighter needs.

"Identifying gaps allows me to then say, 'I have limited money. Here are our real problems, and this is the gap I have to close,'" Prusaczyk explained. "It helps me quantify that as well, so I know how soon I can deliver that capability to the warfighter."

Once gaps are identified and priorities are determined, medical research can direct its efforts toward seeing results in the field.

"This will allow us to focus our limited resources for medical research and development to deliver products, training, and education that will enhance the capabilities of the corpsmen in particular," said Prusaczyk. "That's been my focus: FMF (Fleet Marine Force) and corpsmen for far forward medical care, saving lives, and stabilizing wounded far forward."

Jeffries added that the symposium mission was based on the 21st Century Maritime strategy, the national strategy, the Commandant of the Marine Corps' 2025 vision and strategy, the CNO's future priorities and goals, and the Naval Operations Capability coming out. "So ours is to start now to have solutions for 2015, 2020, and 2025," he said.

–Story by MC1(SW) Arthur N. De La Cruz, USN.

NMCSD LEADS THE WAY IN IMPLEMENTATION OF WHO SURGICAL CHECKLIST

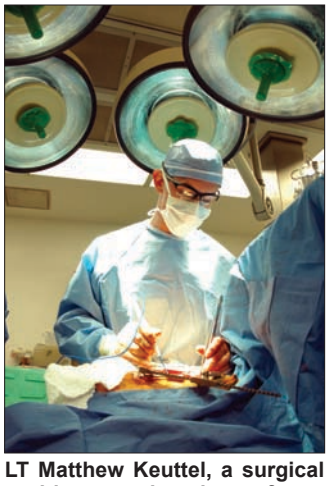
Naval Medical Center San Diego (NMCSD) recently implemented a pilot program to test a new surgical checklist aimed at improving communication and providing a more comprehensive way for surgical teams to perform operations.

The checklist is based on a new format developed by the Institute for Healthcare Improvement (IHI) at the request of the World Health Organization (WHO).

CAPT Jose Acosta, Director of Surgical Services at NMCSD, said two departments at the hospital are already using the checklist.

"I attended the IHI conference in December where the checklist was introduced," Acosta said. "As soon as I got back to San Diego we put a team together to assess exactly how we would implement [the checklist] ASAP."

Acosta said NMCSD had a "Surgery Time Out" system in place, which allowed a surgical team to take a moment before making an incision to double-check their information, but the new checklist is much more thorough.



LT Matthew Keuttel, a surgical resident, assists in performing a thoractomy to remove a cancerous portion of a lung. Before, during, and after the procedure, the WHO surgery check list was used. Photo by MC3 Jake Berenguer, USN

The standard WHO checklists includes 19 steps such as making sure the patient has identified himself and given consent, confirming all surgical team members have introduced themselves by name and role, and confirming instrument, sponge, and needle counts are correct. The checklist can be modified to better suit the needs of individual facilities.

"We did customize the checklist a little, adding steps such as making sure the proper equipment is available and administering prophylaxis to prevent blood clots," Acosta said.

The WHO checklist was developed in response to statistics showing that out of more than 234 million people worldwide that will have major operations this year, approximately one percent will die from complications that could have been prevented.

According to a special article recently appearing in *The New England Journal of Medicine*, eight hospitals in eight cities around the globe, representing a variety of economic circumstances and diverse populations of patients, participated in testing the new checklist between October 2007 and September 2008.

Use of the checklist in these eight hospitals was associated with a reduction of the death rate from surgery by almost half and the reduction of complications by more than a third.

For more information on NMCSD, visit www.med.navy.mil/sites/nmcsd

–Story by MC2 Alexander Ameen, USN.

OFFICIAL ANNOUNCEMENT OF THE 2009 ARMED FORCES OPERATIONAL MEDICINE SYMPOSIUM (IDC CONFERENCE)

The Navy Independent Duty Corpsman and Air Force Independent Duty Medical Technician Associations would like to cordially invite all Navy and Coast Guard Independent Duty Corpsmen, Air Force Independent Duty Medical Technicians, Preventive Medicine Technicians, Medical Service Officers of Military Sealift Command, Medical Service Corps Officers, Nurse Practioners, Physician Assistants, and any United States Army equivalent to the 3rd Annual Joint Armed Forces Operational Medicine Symposium (AFOMS).

The symposium is the premier military operational medicine event that brings together officers, enlisted, and civilian healthcare professionals from various services and communities for an exchange of continuing medical education and experiences.

The symposium will be held at the Sheraton Hotel and Convention Center, New Orleans, LA.

14-19 June 2009.

1,519 rooms have been reserved at $116 per night to accommodate attendees.

To make reservations online, go to http://www.starwoodmeeting.com/Book/idc1

If you choose to make reservation by phone (888-627-7033) you must identify yourself as attending the IDC/IDMT symposium when you make the reservation.

Early online registration fee will be $100. Early online registration will stop on 15 May 2009.

Online registration after 15 May will be $150. Online registration will close on 07 June 2009.

There will be onsite registration. Fee for onsite registration will be $175.

To register online: Log onto, http://www.hjf.org/events/2009-idcidmt.html

This is the Henry Jackson Foundation website for the Advancement of Military Medicine.

Uniform will be: Air Force = BDU/Flight Unit; Navy= Khakis/working white; Coast Guard = Service or Duty Uniform, MSO = Uniform equivalent to Navy/civilian attire and U.S. Army = any uniform equivalent to other branch services.

POC for questions or concerns is HMCM Tommie Thompson at (202)762-3472, e-mail: tommie.thompsonIII@med.navy.mil and HMCM Keith Boyce at (202)762-3471, e-mail: keith.boyce@med.navy.mil

Sailors from FMTB West in Cameroon

HMC Beth Nilson and HM2 Borjorquez from the Field Medical Training Battalion (FMTB) at Camp Pendleton, CA, recently had the unique opportunity to travel across the globe to Cameroon and provide a Combat Lifesaver course.

At first they believed they would be teaching U.S. Marines since MARFORCOM had requested a Combat Lifesaver course which is typically tailored to junior Marines; however, as they prepared for the trip, they realized they would be instructing a group of Cameroonian Medical Marines.

They immediately redesigned the CLS course based on that information. This presented a host of issues which had to be addressed. HMC Nilson stated "We could not teach them the typical CLS because they do not have the same type of equipment that we have i.e., Quick clot, IV fluid, emergency cric kits, etc.

HMC Beth Nilson and HM2 Borjorquez in Cameroon, Africa.

We had to go back to the basics such as improvised bandages, splints, tourniquets, etc." Once in Cameroon, the sailors traveled to a small Marine base in the city of Limbe. They met up with 19 students, only 3 of which were actually Medics. Once again they adjusted to make it more simple, since most of these men had no medical background. After spending 3 days in Limbe, the sailors traveled to the city of Doula where we gave a 1 day advanced training class to 9 actual Medics/Firefighters.

–Hospital Corps Newsletter.

NCR Military Medical Facilities Will Be Jointly Manned

On 15 January 2009, Deputy Secretary of Defense Gordon England approved the establishment of joint commands at the Walter Reed National Military Medical Center and the community hospital at Ft. Belvoir. These new Joint Commands will report to the Joint Task Force National Capital Region Medical (JTF CapMed). The new facilities will be staffed, as joint rather than single service billets, with a mix of military medical professionals from the Army, Navy, and Air Force.

This unprecedented and transformational decision ushers in a new model for healthcare delivery in the National Capital Region. While military hospitals have traditionally provided care to beneficiaries from all services, Military Treatment Facilities have never been staffed with a representative mix of medical personnel from the service medical departments.

This decision is the second in a series of decisions designed to implement an integrated regional approach to military healthcare and achieve unity of effort. The first decision approved by the Deputy Secretary of Defense on 20 October 2008 was the use of a single Department of Defense (DOD) civilian personnel staffing model at National Capital Region medical facilities. This means that ultimately current Army, Navy, or Air Force civilian personnel in the region will become a DOD civilian workforce.

VADM John Mateczun, Commander JTF CapMed remarked, "These decisions provide the foundation that will allow us to achieve one of the nation's premier regional healthcare systems for our patients while enhancing the services' ability to provide fully trained and ready expeditionary medical forces. Our skilled and dedicated civilian workforce will have new opportunities for career development that will be unprecedented."

The plans for implementation of these transformational decisions are in development. The BRAC law requires that the new facilities be fully operational by 15 September 2011. The manning documents for the hospitals have been undergoing spiral development and will now take the form of a Joint Table of Distribution or JTD. A Civilian Human Resources Council has been chartered with representation from the service systems as well as DOD. The JTF staff and component commanders are completing an organizational structure for the new hospitals that will incorporate best practices and bring together some clinical services in new ways to enhance patient care.

Additional information about transitional changes in the NCR will be posted on www.JTFCAPMED.mil

–Story by Kristi Kelly, JTF CapMed Public Affairs.

A Pair of Scissors and a Snipped Ribbon Ushered in a New Day for Medical Treatment

The new Kabani Medical Clinic provides a venue for future medical engagements and Iraqi doctors to treat Kabani's population. "It's a wonderful facility with the potential for being used to provide care. We've done something with positive intentions to do good for a local population, the key to this whole operation out here." LT Scott N. Margraf, medical officer, 1st Marine Logistics Group (MLG) said.

BGEN Robert R. Ruark, commanding general, helps one of Kabani's local leaders cut a ribbon on the new medical clinic. Photo by SGT G.P. Ingersoll, USMC

Kabani, a small village just east of Camp Taqaddum, used to host civil affairs engagements and visits from their own Iraqi medical practitioners in whatever structures they had available. Through a combination of diplomatic action from Iraqi and Coalition Forces, the village now has a necessary venue for healthcare.

"It gives them a place in which a medical provider can render services, which they didn't have before," said CDR Deana J. Miller, family practitioner.

Miller and Margraf also teamed up with two Iraqi Army medics to conduct a combined medical engagement (CME). The presence of Iraqi medics is the next goal, said Miller.

"The next step is getting an Iraqi physician to stay in town, or who might be assigned to several little towns, so that one day he goes to one clinic and another clinic the next," said Miller. "How [Iraq's] Ministry of Health is going to decide how to do that is up to the Iraqis."

The CME was one of many the 1st MLG has performed since taking over in February. The new clinic in Kabani marks the first of many recent steps toward improvements of Iraqi infrastructure.

"It builds the ability for them to support each other," said SMAJ Steven Lara. "[The new clinic] gives them an opportunity to live a more normal life…and the population of the town is growing because of the support they receive."

–Story by SGT G.P. Ingersoll, 1st Marine Logistics Group.

Pet Visitation Making rounds, sharing love at NH Jax

There's nothing like a belly rub, hugs, and kisses to make your hospital visit less stressful. Just ask Molly.

No Molly isn't a patient; she's part of the Naval Hospital Jacksonville staff and she has the hospital ID to prove it.

Four-year-old Molly and her 18-month-old sidekick Teddy are Cavalier King Charles Spaniels owned by CDR Deborah Roy, assistant director of nursing at Naval Hospital (NH) Jacksonville, FL.

Molly and Teddy are the first two dogs in the hospital's new Pet Visitation program. Both Molly and Teddy are exceptionally well-trained, well-behaved, and just plain adorable. Either of them can take a special place in the hearts of young and old alike as they and Roy make their rounds visiting patients, visitors, and staff.

"The dogs provide a positive diversion from the normal hospital environment and help folks feel more at home," said Roy, who initiated the new program here. "Many patients and visitors reminisce about their own pets and their impact in their life," she said. "The visits provide stress relief and a positive interaction that does not involve the medical illness they are being treated for."

Sharon Lassiter and Sharon Galloway take time out from their busy day in the Emergency Department for a moment of pet therapy. Photo by Loren Barnes

Molly may be a plank owner at NH Jax's Pet Visitation program, but she is by no means a novice at her vocation. When Roy was previously stationed at Naval Medical Center Portsmouth, VA, Molly practiced her canine therapy there to the delight of patients and staff. Jazz the Golden Retriever and Jasmine the Collie took up the slack visiting patients when Molly and Roy moved to Florida.

Recognizing that some people are not dog people and others have allergies, Roy said the pets are never introduced to patients, visitors, or staff without their permission or if it would be medically inappropriate.

The hospital is currently looking to expand the program with volunteers who might want to involve their dogs in the program. There are some guidelines for participants Roy said, mainly regarding health and temperament. Dogs must be at least 1 year of age and all breeds are welcome. All dogs must have received their Canine Good Citizen certification. This is a simple obedience test available through the American Kennel Club. Go to AKC.org for information. Dogs must be on year-round flea/tick and heart worm prophylaxis, and must be healthy. All dogs will be evaluated by the NAS Jacksonville veterinarian yearly for a health check.

Dog owners also must be approved. They will be interviewed for the program and will attend the American Red Cross (ARC) orientation program at NH Jax.

After all the criteria have been met the dog's handlers are asked to volunteer for at least 1 hour per month. Roy said that is the ideal amount of time for the dog's rounds. "It takes about 1 hour to complete a set of rounds and dogs get tired around that time."

Pet therapy has been used for years in many places throughout the medical field," Roy said. "Some of the places we see pet therapy being used are in nursing homes (as visitors or as resident pets), physical rehabilitation programs, and

From left, Buzz the Golden Retriever and Molly applied their canine therapy to a patient at Naval Medical Center Portsmouth in 2007. NMC Portsmouth, VA, file photo

hospital-based visitation. Dogs have been used as assistance animals for years and serve as companions as well as helpers for everyday activities. Seeing-eye-dogs help the blind navigate through society. There are even dogs that can sense seizures in their owners before the owners feel the warning signs. Dogs are helping young readers feel more comfortable with their reading and speaking skills. There are service dogs trained to assist people through traumatic events. For instance, dogs were used to assist, aid, and rescue workers during the 9/11 tragedy in New York City. Dogs are helping our returning soldiers through the Paws for Purple Hearts program, where service members with Post Traumatic Shock Syndrome (PTSD) are training service dogs. This helps train needed dogs for service work while helping the soldiers work through their own experiences.

The Pet Visitation program at NH Jax has already resulted in many positive comments from patients, visitors, and staff. From people commenting on "what a neat idea" the program is to remarks on how it "brightened my day."

Staff has also benefited from departmental visits. "One quick stop to pet the dogs provides a brisk relief from the challenges of the day and helps to refuel them," Roy said, noting that she's received numerous requests from departments for therapy visits.

Studies on the medical benefits of interactions with pets, while not offering definitive evidence, have been largely positive. According to the CDC, pets can decrease your blood pressure, cholesterol levels, triglyceride levels, and feelings of loneliness. Pets can increase your opportunities for exercise and outdoor activities and opportunities for socialization.

Of course, most pet owners would say that their pet's biggest benefit is their capacity for unconditional love. Molly and Teddy have plenty of that to share and lots of people to share it with.

–Story by Loren Barnes, Naval Hospital, Jacksonville, FL, Public Affairs and Deborah Kallgren, NMC, Portsmouth, VA, Public Affairs.

CJTF-HOA Reaches Out to Ethiopians During Medical Civic Action Project

Service members assigned to Combined Joint Task Force-Horn of Africa (CJTF-HOA) made a series of house calls during a medical civic action project (MEDCAP) in Ethiopia 28 January - 13 February at Dire Dawa, Ethiopia (NNS).

Personnel from each military branch and several occupational fields worked with local government and volunteers to deliver free care to 5,097 villagers in four remote locations.

"Some of these people have never seen a doctor or dentist before," said mission officer in charge SSGT Scott Regiec, USA. "That's why we need to see as many as we can."

Villagers speaking diverse languages like Somali, Oromo, and Amharic lined up for their chance. Physicians, corpsmen, and medics brought medicine and expertise in 20-plus-vehicle convoys over miles of rough terrain.

"The 3-hour drives were really rough, but we helped a lot of people," said HM2(SW/AW) Mandy Plante, an Individual Augmentee. "I've been to foreign countries before, and I've had a good time doing that, but this is the first time I've gone somewhere and given them medical care. It meant a lot to me that I got to do that."

With the help of force protection and civil affairs personnel, the team set up orderly working sites at Milo, Aydora, Dire Teyara, and Germam. Village chiefs prioritized the patients ahead of time.

"This is a proven method for efficiently improving the health of large numbers of people," said MAJ Remington Nevin, USA, a public health physician. "Reaching as many people, in as many regions as possible, with a proven intervention is key to a successful public health mission."

From there, many saw providers, both those attached to CJTF-HOA and others on temporary assignment.

"I was asked to come here as a pharmacy tech and help manage the operation," said MSGT Rey Garcia, USAF. "With every MEDCAP we do, we tailor the medication we bring to the region. For example, we brought multivitamins to help deal with the malnutrition that sometimes occurs in rural areas. These things take about a year to put together, so a lot of planning is involved."

Garcia helped issue the vitamins and other medications including acetaminophen and antibiotics to about a third of the patients seen. Others received dental care from both experienced dentists and enlisted personnel training on the job. This team gave out antibiotics and performed tooth extractions, including multiple extractions for some people. HN Daniel Badillo, who was on his third MEDCAP, performed many of these extractions.

LCDR Tammi Penhollow checks a woman's throat while a local medical provider looks on.
Photo by TSGT Joe Zuccaro, USAF

"Some of the most rewarding things I've gotten to do on these deployments are exercises like this. The people really want the help, and when you give it to them, their faces are just overwhelmed, which makes you want to do your job even more. This made my deployment very enjoyable, it's why I wanted to come to Africa," said Badillo.

While it aided the health and welfare of the Ethiopian people, the MEDCAP was primarily a Civil Affairs Mission intended to demonstrate effective cooperation between the Ethiopian government, Ethiopian Ministry of Health, and U.S. Africa Command, according to MAJ Michael Wheeler, USA, mission commander. The physicians involved called it an effective way to improve stability in the region and enhance the Ethiopia-U.S. relationship.

"Poor health breeds insecurity, and insecurity leads to breakdowns in public health that threaten millions of lives," said Nevin. "While local governments continue to build on their successes in public health program oversight and management, the assistance of international partners, including the United States, will remain an important part of the solution, particularly in purchasing and supplying medications and in facilitating their delivery."

Garcia has spent the last 2 years traveling to MEDCAP sites around the world, and he agrees that this is one of the best ways to show concern for citizens where they live.

"These nations are in need, and we basically come to help them understand a better way of living," Garcia said. "You can touch thousands of lives by teaching them that something as simple as how washing their hands can help stop the spread of disease. And I think we did that very well here."

As a way of maximizing the opportunity, every villager who entered one of the sites received a goodie bag containing toothbrushes, toothpaste, antibacterial soap, and multivitamins. This section, like the others, functioned smoothly thanks to both the military team and the local volunteers who helped at each site.

"There are no hospitals or pharmacies at these villages, we are bringing these things to them," said John Tesfay, a sound technician from Dire Dawa and one of the volunteers who provided the labor and interpretation services that made MEDCAP possible.

"I am happy to work with the Americans and help my people. I know it makes it easier for them to get help when they see us doing it with the Americans."

The team also coordinated with local government officials, like Hassan Ali Jama, Aydora tribal chairman, who ensured care went to those who needed it most, like sick children and the elderly.

"I really have to thank the Americans on behalf of my people," said Ali Jama. "This helps us so much. From the beginning, the Americans have done more than anyone else to bring us from darkness into brightness. We look forward to more help in the future."

The military team members were also excited to see Ethiopia and interact with its people.

"The Ethiopian people are very warm and helpful to one another and welcoming towards Americans," said HM1(FMF) Sheila Biag.

"Ethiopia is awesome," added Plante. "The people are so friendly. When we were leaving one of the villages, all the people were clapping and singing for us, and two women came up to me and gave me a hug. I took a picture with them. That was really nice that they were so happy that we were there."

Provider MAJ Marc Raciti, USA, said he was pleased with the team's ability not only to accomplish the mission, but to adapt and overcome unexpected difficulties.

"When you have a complicated MEDCAP mission like this where there are so many moving parts, one of the big things is to maintain your 'hit marks', time of departure, getting there on time and setting up on time, and we were very successful at doing all that, even though we had problems," said Raciti, an orthopedic consultant.

"Our vehicles got flat tires, they would get stuck in soft sand, but we managed to do our mission and do it well. We just kept getting better and evolving as a team; we went from yielding a very small population the first day to seeing the most patients during the shortest amount of time the last day. You could really see how the team was pulling together in the spirit of the whole mission."

In addition to the medical assistance, the team gave out shower shoes collected by teachers from Isbell Middle School in Santa Paula, CA. MC1 John Johnson, USNR, asked for help in collecting the shoes and gave them to the team to distribute at the MEDCAP sites.

"The first time I went to Uganda on a mission, I saw so many people walking around without any shoes," Johnson said. "Flip-flops are cheap and wearing them can keep you from getting ringworms and other parasites, so it's a really easy way to help. I'm glad I got people back home involved, people who would normally never think about helping folks in Africa."

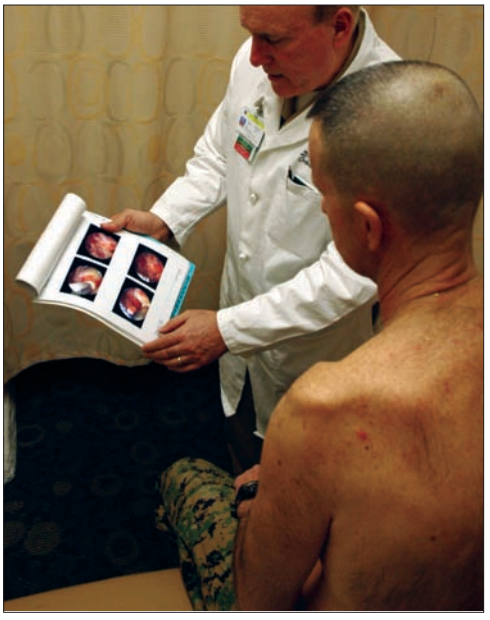
According to Nevin, CJTF-HOA conducts MEDCAPs in several countries in the area of responsibility, including Djibouti, Ethiopia, Kenya, Tanzania, and Uganda.

For more news from Combined Joint Task Force—Horn of Africa, visit www.navy.mil/local/cjtfhoa/

–Story by MC1(SW) Dustin Q. Diaz, USN.

NMCSD Surgeon receives the COL Brian Allgood Award for Orthopedic excellence

The Society of Orthopedic Surgeons (SOMOS) recently awarded the first COL Brian Allgood, M.D. Military Orthopedic Leadership Award to CAPT Dana C. Covey, Chairman of Orthopedic Surgery at Naval Medical Center San Diego (NMCSD).



CAPT Dana Covey explains an injury with a patient. Photo by MC3 Jake Berenguer, USN

The award memorializes Allgood who was killed in combat 20 January 2007 while serving in Iraq. Candidates for the Allgood award are military orthopedic surgeons that have shown a strong commitment to the ideals of duty, honor, and country. The award recognizes the military orthopedic surgeon who has distinguished himself as an exceptional leader and medical practitioner in the care of injured service members.

"Dr. Covey was selected among nominees from the Army, Navy, and Air Force to receive this prestigious 'life-long' achievement award in military orthopedic surgery. For SOMOS, this is our highest award as an orthopedic surgeon. This year was the first year of the award," said NMCSD staff surgeon, CAPT Scott Helmers.

"It's a big honor to have received the award. I would like to think that I was chosen as a representative of the leadership, operational, and patient care contributions of many in Navy medicine and Navy orthopedics. All that we accomplish is a result of a team effort," said Covey.

Covey has never shied away from significant leadership dedicated to the prevention, diagnosis, and treatment of diseases and injuries of the musculoskeletal system according to Helmers.

Covey's leadership responsibilities, at home, overseas, and in combat zones made him an excellent candidate according to Helmers. He is also one of the few military orthopedic surgeons to be to be inducted into the American Board of Orthopedic Surgery (ABOS).

"It's great to work for someone as accomplished and knowledgeable as Dr. Covey. His orthopedic expertise contributes so much to our efforts to improve the quality of life for others," said Orthopedic Surgical Sports Clinic technician, HM3 Class Kristi Warren.

Covey has served as Chairman of the Orthopedic Surgery Department and Residency at NMCSD from 2004 to present. This does not include his decade of service during three consecutive appointments as the Navy Orthopedic Specialty Leader and consultant to the Surgeon General, where he also served on the Board of Directors for SOMOS.

His outstanding military service has earned him multiple personal military awards including a Legion of Merit, Bronze Star, two Meritorious Service Medals, two Navy Commendation Medals, and two Navy Achievement Medals, in addition to numerous unit ribbons and medals.

–By Mass Communications Specialist 3rd Class Jake Berenguer.

Deployed Audiologist, Corpsman, and Clinic OIC Recognized for Service

Naval Hospital Pensacola Commanding Officer, CAPT Maryalice Morro, NC, presented awards at an informal awards ceremony in front of the hospital 30 January.

LCDR Kimberly Gullickson, Regional Audiologist for Naval Hospital Pensacola's Public Health directorate was presented her third career Navy Commendation Medal for here clinical services at Naval Branch Health Clinic (NAS) Pensacola.

During her tenure, LCDR Gullickson ran all occupational audiology services for more than 25,000 active duty military personnel and civil service employees in the Pensacola hospital's region. Also during this period, Gullickson supported the global war on terrorism when deployed to Guantanamo Bay, Cuba, where she fit hearing amplification devices for detainees, thereby establishing audiometric testing facility specifications for the detention facility.

LCDR Michael S. Kohler, Officer-in-Charge of NBHC (NAS) Pensacola, was presented his fifth career Navy Achievement Medal for his professional achievement and performance NH Pensacola's Operational Training Officer from September 2007 to August 2008.

Kohler developed and directed a complex operational training program designed to encompass all platform training requirements into a single plan which had an immediate readiness impact for more than 350 personnel monthly.

He also augmented training to support mission-performance standards that included 25 baseline pre-deployment requirements that culminated in a successful mass casualty exercise involving three local commands.

From left: LCDR Kimberly Gullickson; LCDR Michael S. Kohler; and HM3 Rachel DeJong. Photo by MC1(AW) Russell C. Tafuri, USN

HM3 Rachel DeJong, assistant to the hospital Command Master Chief, was presented with the U.S. Department of Defense Humanitarian Service Medal for her service while deployed to Tbilisi, in the Republic of Georgia, in support of Operation Assured Delivery, where humanitarian relief assistance was provided following hostilities with the Russian Federation last summer.

Milo J. Jablonski, medical support assistant for the Laboratory, Occupational Therapy and Radiology departments, was presented a Career Service Award, signed by the Secretary of the Navy Donald C. Winter, in "grateful recognition and appreciation" of his 40 years of faithful service to the U.S. Navy and to the government of the United States. He was also presented a service pin, a framed photo of former President George W. Bush, and a certificate of service.

Barbara Cotton, administrative assistant in the Laboratory and Clinical Pathology departments, was presented a government service recognition pin and certificate for her faithful and loyal 25 years of service.

Donna K. Griffin-Jenkins, a financial technician for the Directorate for Resource Management, was presented a government service recognition pin and certificate for her faithful and loyal 20 years of service.

–Story by MC1(AW) Russell C. Tafuri.

Lejeune Corpsman Awarded Bronze Star

CAPT Gerard Cox, Commanding Officer, Naval Hospital Camp Lejeune presented the Bronze Star to HM2 Stephen Blas in a ceremony held at the Naval Hospital, 14 January.

Blas, a 24-year old general duty corpsman, was awarded the Bronze Star for prolonged medical services rendered to an injured soldier during combat in support of Operation Enduring Freedom, while serving with Embedded Training Team, (ETT) Medical NCO Mentor for HHC, 2nd Battalion, 2nd Brigade, 205th Corps, Afghan National Army (ANA) and primary medical provider for 2-2-205th ETT's.

During combat operations, he executed his duties in an exceptional manner at several of the most dangerous locations within the Islamic Republic of Afghanistan.

He was the first medical personnel to respond to the IED attack where he provided immediate attention to a soldier. Since medical evacuation was not available, Blas risked his own life riding in the back of an ANA 7-ton truck, exposing himself to enemy attack to continue treating his patient.

In a separate attack against his unit, they found themselves outnumbered and pinned down with a malfunctioning weapon. Blas dismounted the vehicle and began to return fire with his personal weapon. While on another patrol, his unit came under direct enemy fire, which resulted in his executive officer suffering from shrapnel wounds and suspected traumatic brain injury (TBI). A MEDEVAC flight was requested, but not available. HM2 Blas continued medical care throughout the night for 15 hours until the patient could be successfully evacuated. Blas is credited with saving his executive officer's life. During another attack, a soldier and U.S. interpreter triggered a deadly IED fatally wounding two soldiers and wounding another soldier and U.S. interpreter. Blas stabilized the soldier and the interpreter and remained with them until they could be evacuated.

"Giants stride across the face of the earth every day and today, a true hero walks among us," said CAPT Cox.

"I am very proud and honored to receive this award. It was a team accomplishment related to the mission that we were there to do. I am very proud to represent Navy medicine there and here," said Blas.

–Story by Raymond Applewhite, Naval Hospital Camp Lejeune Public Affairs.

CAPT Cox, presents HM2 Stephen Blas with the Bronze Star. Photo by HM3 Ryan Keith, USN

Goal Oriented Corpsman Offers Unique Perspective

HM3 Ismail Abuhussein of Naval Hospital Bremerton (NHB) has been conducting training sessions for individual augmentees deploying to the Middle East.

"Having grown up and lived in the Middle East, I have an obligation to dispel rumors about the region," said Abuhussein. "There are many cultural aspects that sharing information about can simply make them more approachable and understandable. The United Arab Emirates (UAE) is a prime example that an Arabic society can be just as modern and diverse in places as in Western societies."

Abuhussein has presented introductory cultural and language training several times to other staff members who have received individual augmentee orders to the Middle East. He has covered basic linguistic phrases and historical background, explained common courtesies, expounded on culinary differences and perhaps most importantly, taken the time to explain cultural "dos and taboos" commonplace in a predominantly Middle Eastern Arab country."For example, I went over very common Arabic [language] that could and would be used on a daily basis, such as basic phrases and greetings," Abuhussein said. "Just knowing how to meet and greet someone can make a world of difference and help to defuse any potential tension."

Abuhussein has followed a circuitous route to his current command that has taken him from being born in Bethlehem, to raised in Dubai, UAE, to a soccer scholarship at a small school in Rockford, IL, where he found out about the U.S. Navy. "I got interested and joined because there is a lot of opportunity here," he explained. "Having education paid for is a huge plus. Education is so important and very doable while on active duty."

For Abuhussein, his schooling is part of an overall scholastic goal that is advancing in planned stages. To apply for a Health Services Provider Scholarship, he must first qualify with having completed the necessary undergraduate classes. He is well on his way. He has accumulated 70 credits with top marks across the board and a few classes remaining. The scholarship he is aiming for will take him into his chosen field.

"Dentistry is my calling and I'm at a command that has given me the chance to do my best," said Abuhussein.

But that opportunity was not initially welcomed by his family. It took determination and dedication to convince them that his career goals were achievable in the Navy. "My family was against me joining [the Navy]. They thought such a move was too risky. But now they are very supportive. I wanted to be independent, organized, and accomplished on my own. They are impressed by the amount of educational advances I have already achieved in less than 3 years in the Navy. They are very proud. They didn't think I could do such things in the Navy."

HM3 Ismail Abuhussein (middle) discusses soccer strategy with Naval Hospital Bremerton teammates during a planning session for the upcoming season. Photo by Douglas H. Stutz

Abuhussein hopes that some day his Navy experience and education will enable him to return to his roots to help those less fortunate. Despite being a major tourism destination for three of the world's major religions, Bethlehem has its share of poverty stricken pockets. "Healthcare there is very minimal. There are lots of local remedies that are used instead of updated medical and dental services that we have here," he said. "I have always wanted to do something to help, such as volunteer work and humanitarian assistance with dental hygiene skills to provide dental care to those who don't have any or have never been seen by a dentist."

Abuhussein also has a passion for soccer. "We would play anywhere as children. All we needed was a ball. We could start a game in an alleyway or an open field. What makes soccer so popular is that it is so simple. There just isn't a lot of equipment that's needed."

Abuhussein is currently helping NHB's team prepare for the upcoming season. There are non-stop 90 minutes practice sessions, along with conditioning runs several times a week, as well as ball handling and dribbling drills. Talking about soccer has Abuhussein animated and energetic, just as explaining his education has him focused and earnest. The common objective is the same for both topics...goal!

–Story by Douglas H. Stutz, Naval Hospital Bremerton Public Affairs.

Where in the World is Jeff Plummer

Multi-National Security Transition Command – Iraq Release

Multi-National Security Transition Command-Iraq's Health Affairs directorate hosted some very specialized training for the staff of the Iraqi Navy's Medical Clinic here, 3 February.

In cooperation with U.S. Naval Forces Central Command, Health Affairs sponsored a course in Undersea and Diving Medicine for the sole Iraqi physician and 10 of his medical staff at this strategic and developing naval base.

With a growing diver force, the unique requirements for providing healthcare to an undersea force demand a very specialized skill.

MGEN Samir, Ministry of Defense Joint Forces surgeon general, and CDR Jeff Plummer, MSC, deputy director, MNSTC-Health Affairs, traveled to Umm Qasr for the 3-day site visit, linking up with the NAVCENT instructor enroute. CAPT Dale Molé, MC, NAVCENT and 5th Fleet Surgeon, is an Undersea Medicine instructor and certified U.S. Navy diver.

Molé agreed to travel to Umm Qasr to conduct the diving medicine course at the request of the Iraqi Surgeon General. Further, this allowed NAVCENT to pre-screen the Iraqi Navy physician, CAPT Muayed Mansour, in advance of his nomination to attend the Undersea Medicine 9-week dive course in Panama City, FL, later this year.

Samir's presence for the course was vital, as he provided medically relevant English to Arabic translation. With only one physician in the class, Samir often had to expand the training with explanations of medical concepts and anatomy for the medics and divers in the room.

Samir reflected, "Although often a difficult translation, today's experience allowed me to break my mind from our everyday challenges at the MoD and return to my calling. I enjoy discussing and teaching medical concepts."

CDR Jeff Plummer, MSC, OIC of Branch Health Clinic, NAS Whiting Field, FL, volunteered for Individual Augmentee duty in July 2008. He assumed the position of Deputy Director, Multi-National Security Transition Command-Health Affairs. He has degrees from the University of Florida and Baylor University. CDR Plummer has been selected for the rank of Captain.

Upon his return from Iraq, CDR Robert D. Reuer, MC, family practice and flight surgeon deployed in 2006 from Branch Health Clinic, NAS Pensacola, FL, reported to Branch Health Clinic, NAS Whiting Field, FL, and assumed the duties for Senior Medical Officer and Acting OIC in CDR Plummer's absence.

CDR Plummer returned to his OIC duties in March 2009.

CDR Jeff Plummer and Iraqi MAJ Ali Maghloom (right), Surgeon General's Office Assistant Director of Logistics, dedicate the new medical warehouse at the Kirkush Military Training Base.
KMBT file photo

Coalition efforts accelerate growth of medical logistics

Highlighting the accelerated growth of medical logistics in Iraq, the Ministry of Defense Director of Logistics and the Multi-National Security Transition Command - Iraq Health Affairs directorate presided over the ribbon-cutting 12 January 2009, for a new medical warehouse at the Kirkush Military Training Base.

"The purpose of this mission was threefold: support the Surgeon General's logistics staff as they launch operations of the class VIII medical warehouse, inspect the coalition-built Iraqi outpatient medical clinic and review the Basic Medic Course training program," said CDR Jeff Plummer, Deputy Director, MNSTC-I Health Affairs.

The Iraqi medical logistics system is growing more and more independent every day. In addition to five Class VIII warehouses at the Taji National Depot, there are seven geographically-dispersed sub-warehouses in the Surgeon General Office's plan for medical supply distribution.

MNSTC-I Medical Logistics Officer, MAJ Ed Rodriguez noted, "The opening of the Kirkush facility marks the third sub-warehouse placed into operation. Our next step is to bring Iraqi theater medical logisticians to MoD Class VIII warehouse locations for detailed and professional warehouse management training.

The new warehouse, along with other joint efforts to bolster the MoD's medical system, is another milestone towards strengthening Iraq's security and sustainment capabilities.

Plummer awarded Bronze Star Medal for service in Iraq

COL Stephen Salerno awards the Bronze Star to CDR Jeff Plummer. Photo by LCDR R. Conway

CDR Jeff Plummer was awarded the Bronze Star for exceptionally meritorious service during Operation Iraqi Freedom while serving as Deputy Director for Health Affairs at the Multi-National Security Transition Command-Iraq (MNSTC-I). Conducting over 50 combat missions throughout Iraq, CDR Plummer led a team of Army, Navy, and Air Force medical officers and non-commissioned officers advising/mentoring the Iraqi Ministry of Defense (MoD) Joint Forces Surgeon General Office, and the Ministry of Interior (MoI) Health Directorate.

On his watch, significant health service support capability was transferred from Coalition to Iraqi control. The first Iraqi MoD Military Hospital at Al Muthana was opened on 19 January 2009, enabling key inpatient services in the capital city of Baghdad. Medical supply warehouses were expanded in Taji, Kirkush, and Numaniyah ensuring support for a growing medical logistics system.

A less mature MoI Health Directorate required more focused intervention for positive progress. CDR Plummer directed high-level engagements by senior coalition advisors with the Iraqi Minister of the Interior, resulting in governance changes that better recognize health services. In addition to constructing seven clinics for the MoI National Police, MNSTC-I Health Affairs outfitted National and Border police with ambulances and supplies, and advised MoI forces on establishment of medical logistics procedures.

Achieving a significant milestone for the developing Government of Iraq, CDR Plummer organizing a first ever dinner conference between the leaders of the Ministry of Health, MoD and MoI. Hosted by the MNSTC-I Commanding General and chaired by Deputy Prime Minister Rafi Al Isawi, and orthopedic surgeon, this event was lauded as a major first step toward cross-ministerial cooperation for the developing healthcare infrastructure.

–All Stories by Multi-National Security Transition Command-Iraq Public Affairs.

RADM Christine M. Bruzek-Kohler will be assigned as Commander, Navy Medicine West/Commander, Naval Medical Center/ Director of the Nurse Corps, San Diego, CA. Bruzek-Kohler is currently assigned as Deputy Chief, Medical Operations, M3/5, Bureau of Medicine and Surgery/ Director of the Nurse Corps, Washington, DC.

RADM Christine S. Hunter will be assigned as Deputy Director, Tricare Management Activity, Office of the Assistant Secretary of Defense for Health Affairs, Washington, DC. Hunter is currently serving as Commander, Navy Medicine West /Commander, Naval Medical Center, San Diego, CA.

Secretary of Defense Robert M. Gates announced today that the President has nominated CAPT Brian P. Monahan, MC, for appointment to the grade of rear admiral and assignment as Attending Physician to Congress. Monahan is currently serving as Deputy Attending Physician to Congress.

RDML Michael H. Mittelman has been nominated for appointment to the rank of Rear Admiral (upper half). Mittelman is currently serving as Medical Officer, Joint Forces Command, Norfolk, VA.

RDML Matthew L. Nathan has been nominated for appointment to the rank of Rear Admiral (upper half). Nathan is currently serving as Commander, Navy Medicine Capital Area and Commander, National Naval Medical Center, Bethesda, MD.

RADM Christine S. Hunter, Commander, Naval Medical Center, San Diego, presents the Bronze Star to CDR Joey Swartz, for his exceptional meritorious service while deployed in support of Operation Enduring Freedom at Combined Security Transition Command, Afghanistan. Photo by MC3 Jake Berenguer, USN

NMCSD Provides Maxillofacial Prosthetics

MC3 Jake Berenguer, USN

Prosthetic eyes, noses, and rebuilt skulls are not often associated with dentistry. However, Naval Medical Center San Diego (NMCSD) dental technicians restore birth or acquired disfigurations of the head and neck region through maxillofacial prosthetic services.

The maxillofacial prosthodontists adds some normalcy to a patient who has lost an eye, ear, or nose by recreating a custom prosthetic to hide the damaged area using a wide variety of materials such as acrylic, porcelain, and silicone. The Navy only has 11 prosthodontists worldwide. NMCSD's Dental Department boasts two of them.

"It's a very special and unique thing we do here. Because we are in the dental field, we have experience creating prosthetic pieces such as teeth. The prosthetics we create in the maxillofacial clinic are far more complex," said LCDR Todd Carpenter, MC, a NMCSD maxillofacial prosthodontist.

HM2 Daniel Cortez forms a wax a frame around a prosthetic eye before creating a silicone frame to hold the eye in the socket.
Photo by MC3 Jake Berenguer, USN

"We are trained at Bethesda Naval Medical Center in Maryland. It was really on the job training in a class setting," said HM2 Frank Lemus, NMCSD maxillofacial prosthetics laboratory technician. "We learned how to work with all the different materials and how to make the prosthetics, and then we started making them for actual patients. We were previously trained to make teeth, and ocular pieces made from similar materials. We learned how to match eye colors and hand paint irises to precisely match their eye color."

The technicians create ear, eye, tooth, and other maxillofacial prosthetics using molds, photos, and precise measurements to replicate the patient's skin tone, texture, or eye color. These efforts are all done to improve a patient's quality of life and self image, according to Lemus.

"Patients often are very self conscious about a facial deformity. People notice your face first and constant double-takes are extremely troubling. People are a lot less subtle than they think, and they can demolish someone's self esteem," said Lemus.

The maxillofacial prosthodontists create the pieces by placing a silicone compound in a mold of the existing ear if possible or with the empty ocular cavity and then create a wax version of the prosthetic with molds. After a fitting is done and final adjustments are made, they can create the patient's finished custom prosthetic piece. By going as far as placing microscopic red veins in an ocular piece or fixing a cleft pallet helps patients regain a sense of normalcy, according to Lemus.

"With strong attention to every detail of their skin tone, texture, or eye color, the prosthetic piece will fit the patient and alleviate any of the previous insecurities they were experiencing. Our goal is to improve their lives. We have gotten so much good feedback from our patients. It feels great to know that I have helped give a person back some of their self esteem," said Lemus.

HM2 Daniel Cortez applies a red fiber to a prosthetic eye to simulate a vein. Photo by MC3 Jake Berenguer, USN

HM2 Frank Lemus tints a silicone prosthetic ear. Photo by MC3 Jake Berenguer, USN

Occasionally they receive requests for a custom piece such as a sports team logo or a military symbol to be placed on their prosthetic eye.

"We have found that after losing an eye, patients need some laughter in their lives, and we are more than happy to create a custom piece for them," said HM2 Daniel Cortes, an NMCSD maxillofacial prosthetics laboratory technician. "We get a lot of requests for sports team logos to be used in the prosthetic eyes. There are a lot of one-eyed Charger fans here in San Diego. We also recently did a custom Marine Eagle, Globe, and Anchor eye."

Working for all branches of service, beneficiaries, and retirees, NMCSD's maxillofacial clinic is readily available to provide a wide variety of maxillofacial prosthetic services and care to any who need it according to Carpenter.

For more information regarding this topic please visit NMCSD's Dental department home page http://www.med.navy.mil/sites/nmcsd/Patients/Pages/DentalDepartment.aspx

MC3 Berenguer is Flag Photojournalist, Public Affairs, Naval Medical Center, San Diego, CA.

Hospital Corps School Has a New Home

LT Steven Brewster, MSC, USN

"The mission of the Hospital Corps is to give on land, sea, and in the air, intelligent, capable, and efficient assistance to Medical, Dental, Medical Service, Nurse, and Hospital Corps officers in the eternal war against disease, injury, and death, and to aid in maintaining the supply and administrative functions of the supportive branches of the Medical Department; in the absence of these officers, to display the knowledge and judgment required to meet all emergencies and in every possible manner assist to the best of their ability, training and knowledge in the function of the medical department of the Navy, i.e., to keep as many men at as many guns as many days as possible.

This complex mission requires from each member of the Hospital Corps a versatility neither demanded nor expected of other enlisted ratings in the Navy.

Wherever you find the Navy, wherever you find the Marine Corps, there you will find the Navy Hospital Corpsman. In times of peace, he toils unceasingly, day and night, often in routine monotonous duties. In times of war, he is on the beaches with the Marines, is employed in amphibious operations, in transportation of wounded by air, in the front battle lines, on all types of ships, submarines, aircraft carriers, landing craft. In short, wherever medical service may be required, the hospital corpsman is there, not only willing but prepared to serve his country and his fellow man above and beyond the call of duty."

–Handbook of the Hospital Corps, United States Navy, 1953

The Hon. James Forrestal, Secretary of the Navy, and later the first Secretary of National Defense (the precursor to the Department of Defense) wrote a profound and lasting message to the Navy's Hospital Corps immediately following World War II. This message not only described the Navy's and the nation's gratitude for the Hospital Corps, but in some ways helped to define its future by solidifying esprit de corps within its ranks.

Sec. Forrestal wrote, "No wonder men and women are proud to wear the emblem of the Hospital Corps. It is a badge of mercy and valor, a token of unselfish service in the highest calling, the saving of life in the service of your country."

The Secretary closed his message, "Customarily the 'Well done' signal is reserved for the closing phase of a message of congratulations, but I placed it in the forefront where, in this instance, it most fittingly belongs. I repeat it, here, with the postscript that in earning its 'well-done,' the Hospital Corps is assured no other unit in the Navy did better in the degree of essential duty inspiringly performed."

Fast-forward 60 years. The Base Realignment and Closure (BRAC) legislation of 2005 mandated that the Army, Navy, and Air Force must co-locate all enlisted medical education and training programs at Ft. Sam Houston (FSH), San Antonio, TX, by 2011, and consolidate where practical. What?

Field Medical Training Battalion (formerly known as FMSS) is inherently Marine Corps and operational short courses that do not award NEC's (cold weather training, fleet hospital training, etc) are not moving.

How exactly does someone take three Naval Schools of

Physical Fitness Center. All images courtesy of author

Medical Instructional Facilities 1 and 2.

Health Science, the 882nd Training Group of the Air Force, and the Army's Academy of Health Sciences and blend/merge/integrate them into one functional unit? The BRAC law did not require the three services to become one training unit. Rather, it directed co-location. OK. We'll all just be neighbors in base housing, so to speak. But that doesn't make much sense, if we are not going to change our concepts of operation and integrate to some degree, why are we moving in the first place? Are we not supposed to find efficiencies, economies of scale, and ways of working together?

Some things are obvious to the casual observer, a surgical technician is a surgical technician, regardless of the uniform he/she wears (or is he/she). Through countless hours of debate, it became clear that the Army, Navy, and Air Force train their medics and corpsmen in different ways. Ouch. This is not going to be as easy as some thought when they signed off on it.

Honestly, it can not be done on one level, but it is being done on another. It is being accomplished through the dedication and intense efforts of many individuals. It is a process that seems glacial in size and speed some days and Hurricane Katrina or Ike in size and speed on others. Both glaciers and hurricanes leave a mark on the landscape. The implementation time line to accomplish the METC mission most resembles a hurricane, but the accuracy required needs to replicate that of a glacier, not in time, but precision.

Bringing the three services together in small working groups called integrated process teams (IPT) occurs regularly at various levels: higher headquarter discussions on governance and finance, instructor-level discussions on curricula and functional classroom design, etc.

The goal is to create a university-type environment that is fully accredited, offers college credit and degrees for some programs, and maximizes resources to achieve extreme efficiencies.

In the world of individual augmentations and heavy deployment tempos, why not train together? Why not learn how it is done in other services? We work together in combat, so why not train together? Some would argue that because we don't deploy together and have differing missions while deployed, there is no reason to "cross train" to other service requirements.

I'm stepping out on a very thin limb here, but I would posit that anyone who still maintains that view has not yet deployed to Iraq or Afghanistan. In those environments, as all members of each service, you either already know how to, or rapidly figure out how to work with each other. We are not afforded the luxury of depending on our own service at all times, we learn rapidly to step out of our "comfort zones and vernaculars" out of a sheer need to survive. And drilling down another layer; medical is medical, we all breathe and bleed the same, regardless of the uniform, including enemy forces.

Some would challenge that this co-located training will result in one-service medic, the loss of identity for the Hospital Corps and other such dilutions of service culture. The emergence of the "purple suited" medic, so to speak.

Presently, we are constructing three 4-story dormitories (each will house 1,200 students), 5-multi-story education buildings, a 2-story dining facility (the largest in the DOD inventory) and numerous other smaller buildings. In the 7 months since breaking ground, we are already placing the roofs on some of these structures, and the services have agreed to many mergers (or partial mergers) in curricula. But we have also continued to battle the issues of integration without losing service identity. History and heritage are up to the individual owners to maintain. In this regard, maintaining individual service culture is paramount. Yet at the same time, learning how to more closely work with sister services has never been more crucial.

Medical Instructional Facility 3 and 4.

One way the Navy has discovered to preserve the history, and more importantly the honor and integrity, of the Hospital Corps, is to relocate approximately 85 percent of the historic photographs, plaques, and medical memorabilia that currently line the passageways of NSHS Portsmouth, NSHS San Diego, and Naval Hospital Corps School Great Lakes to the METC. Additionally, the Hospital Corps School students will be berthed in a dormitory entirely their own, complete with classrooms designed for Navy-specific training, designed to further develop and refine these young sailors."

Dormitory 1 and 2.

When the dust settles, the entire project will have a $750 million dollar price tag and include the latest technology in all classrooms. The team on the ground and everyone involved is committed to ensuring that this project comes in on time, on budget, and on target. Frankly, we can't afford to get it wrong. The newly established METC will be the premier showcase of enlisted military medical education. METC is our future and the next step in our combined heritage.

But our challenge does not stop there. Rather, that is where is just begins. Naval Hospital Corps School has seen many locations over the history of the Corps, in many forms and many competency training-level requirements. But one thing has remained constant, the esprit de corps of the Corps and its fundamental mission.

Being assigned to the Transformation and Integration Office (TIO), the "pre-commissioning" team for METC, is the assignment of my career. I truly enjoy working shoulder to shoulder with the Army and Air Force. For me, it is an honor to be a part of this endeavor, looking forward to what our final product will be, not the facilities, rather the cross-trained medics and corpsmen, men and women capable of deploying together with less apprehension, uncertainty, and lack of culture variance awareness.

As a young corpsman student many years ago, I would have thought this tri-service training to be excessive, unnecessary, and a waste of time. But having deployed in support of the war on terrorism, I will admit that I wish I had been exposed to this at a young age. If I had learned Army and Air Force cultures early in my career, most of my subsequent assignments would have held a far smaller learning curve in terms of integrating with those with whom I actually served.

In my opinion, there is nothing to fear from relocating Hospital Corps School to an Army Post and sharing some training with the Army and Air Force. There is no risk of the Corps losing its identity, heritage, or prestige. I mentioned previously that we can all learn from each other. That remains true. What I did not mention was how much the Navy has to offer on the teaching side of that equation. I believe this to be not only a call to demonstrate our ability but also a challenge to lead the way, a potential "shining moment" for the Navy. As a former corpsman, I am honored to be assigned the duty, to be a member of the crew building this new university, part of which will become the new home of Navy Hospital Corps School.

Dining Facility

LT Brewster is the Navy Logistics Officer for the Transformation and Integration Office of the Medical Education & Training Campus, Fort Sam Houston, TX.

Grasshopper 16

Roger Ware

The helicopter is one of the lasting symbols associated with the Vietnam War. By the time U.S. combat troops arrived in South Vietnam in 1965, this unique aircraft was hardly a novelty.

Unlike the Army, which had designated helicopter ambulances ("dust-offs,"), the Marines provided medevac on an as-needed basis. During the early phase of Marine operations in Vietnam, LCDR George Harris, commanding officer of B Medical Company of the 1st Medical Battalion, recalls that his unit "never had any dedicated helicopters, that is, helos used only for medical evacuation. They were available on a catch-as-catch-can basis unlike the Army which had whole companies of helicopter ambulances. The Marine theory was that an airplane is an airplane is an airplane, and a helicopter is a helicopter is a helicopter. The belief was that they couldn't afford to sideline a helicopter to move casualties so we didn't have dedicated 'dust-off' helicopters, or 'slicks,' as we called them."

If a casualty required transportation to one of the hospital ships, a phone call to the local Marine Air Group would usually bring a helicopter to the hospital helo pad in short order, if one was available. As Harris and his colleagues learned, an "urgent" ambulance call might well go unheeded if all the group's helicopters were out on a mission.

By 1968, Marine helicopter squadrons located in the I Corps area in northern South Vietnam at Quang Tri, Phu Bai, and Danang were flying daily medevac missions on a rotating basis with designated air crew usually comprising the pilot, co-pilot, crew chief, hospital corpsman, and, if the CH-46 were the aircraft, two gunners for suppressing enemy ground fire.

Duty as a medevac corpsman was strictly voluntary and no specific training was required. HM3 Roger Ware, having been in the "bush" with Fox and Hotel Companies, 2nd Battalion, 5th Marines, was reassigned to a battalion aid station. He frequently volunteered for medevac flights. "If they needed a corpsman, I'd go."

Our call sign at the BAS [battalion aid station] was Grasshopper 16. They'd call in, "Grasshopper 16, this is Flight Line. Need a corpsman for a medevac. Do you have one available?" When the chopper landed at medical, I'd go out and take off with it.

I remember quite a few medevac flights. I'd ride out in a helo somewhere in the field and wouldn't know where I was. I wouldn't be hooked into the flight helmet. I'd just be a body inside that helo. We'd land in an LZ, a field, or rice paddy. They'd then bring a guy up, throw him on the helo, and we'd take off.

The biggest risk I always worried about was going on a night medevac mission. I couldn't see and had no idea where we were going. When a helo began going down into an LZ at night, we flew with no lights on, and just hoped to goodness there were no trees below us. We were being talked down by the radioman on the ground. When I was inside those helos, all I had on was my flak jacket and my gear. The gunners had reinforced armor vests and some extra protection around the machine guns. But if I stood in those doorways, I had no extra protection. It was a hairy feeling being in a helo like that.

HM3 Ira Leavitt treats a casualty aboard an evacuation helicopter. BUMED Archives

In my case, I controlled my fear. I actually was afraid until the helo landed. Then instinct took over and I did my job. When you were doing your job, you never worried about getting shot down. The fear went away. It was the same fear I felt in combat. When I was on patrol, I always worried about something happening that I could never take care of. When I saw some of those injuries, I would be in such shock myself. No matter how much I'd seen, it was never the same. But, as I said, instinct took over.

At night I had to feel for the injuries. I might have had a red flashlight but wouldn't want to use it at night because I didn't want the enemy to see where I was. My biggest fear at night was that one guy would trip a mine and maim everybody around him—and I might be one of them. I also wondered what would happen if I got hit. Who would take care of me?

Roger Ware retired in 1997, becoming the last commissioned warrant physician assistant in the Navy. He resides in Elkins, WV, and is senior vice commandant for the Marine Corps League in that city.

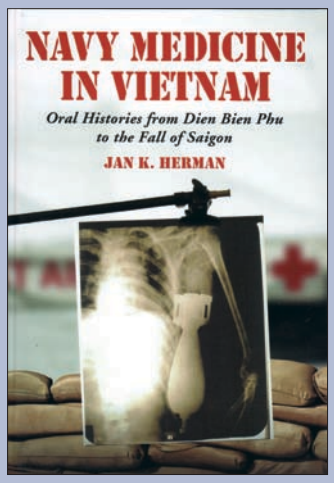
Navy Medicine in Vietnam Oral Histories from Dien Bien Phu to the Fall of Saigon by Jan K. Herman. McFarland & Company, Inc., Publishers. 2008. 357 pages.

As a young intern in Charleston, SC, I visited the World War II aircraft carrier USS *Yorktown* (CV-10) at the Patriots Point Museum. One of the most fascinating exhibits on display was in the medical department, where a chest x-ray was hanging on a viewing box. The x-ray had an opaque image of a mortar shell over the left side of the chest, with an explanation that this live mortar round was removed from a South Vietnamese soldier by a Navy surgical team. That x-ray image is on the cover of *Navy Medicine in Vietnam: Oral Histories from Dien Bien Phu to the Fall of Saigon*, Jan Herman's latest effort in his trilogy on Navy medicine at war.

As in his previous works *Battle Station Sick Bay: Navy Medicine in World War II* and *Frozen in Memory: U.S. Navy Medicine in the Korean War*, Herman allows the participants to tell their stories in the first person. The interviews of the doctors, nurses, corpsmen, and patients tell stories of both extraordinary medical care given under the most adverse conditions, as well as personal heroism. The contrast between idealistic interviews given directly after returning from Vietnam, compared to the often cynical interviews given years later upon reflection of service in Vietnam, almost serves as a human metaphor for the American experience in Southeast Asia. Herman organizes the book's interviews chronologically, with each group of interviews preceded by an historical description of the relevant phase of the war. The result is a chronology of America's involvement in the Vietnam War as seen through the eyes of naval medical personnel and their patients.

The book begins in 1954, with Navy medicine's initial involvement in Vietnam. Almost simultaneously, two major operations were undertaken. The Navy played the key role in the evacuation of sick and wounded French soldiers and former prisoners of war from Saigon, after the French defeat at Dien Bien Phu. The healthcare of over 700 of these French soldiers was the responsibility of Navy medical personnel. The other major operation begun at that time was Passage to Freedom, the evacuation of over 200,000 Vietnamese refugees from Haiphong to Saigon. The first hand descriptions by the medical officers, including the soon-to-be famous LTJG Tom Dooley, make for fascinating reading.

As America's involvement in Vietnam grew, so did Navy medicine's presence. Starting in 1963 from a hospital that was a converted apartment building in Saigon, the medical teams were next sent to outlying provincial hospitals. Soon Navy personnel were operating in larger fixed facilities at places like Danang and Dong Ha. The hospital ships *Sanctuary* and *Repose* off the coast performed life-saving resuscitation to our troops. Navy corpsmen were serving with Marine units in the field and performing remarkable lifesaving resuscitation under intense combat situations. The individual narratives describe what it was like treating casualties in all of these environments.



Herman's narratives tell of extraordinary medical achievements interwoven with almost unbelievable personal heroism. The reader is transported into the operating room as three surgeons describe removing live ordnance from their patients. For his removal of the previously described live mortar shell imbedded in his patient's chest, CAPT Harry Dinsmore received the Navy Cross. We are with the Senior Medical Officer aboard the USS *Forrestal* (CVA-59) in July of 1967 when a fire raged throughout the ship, killing 134 crewmembers. We read of the 77 days that HM3 William Gerrard spent during the siege of Khe Sanh, caring for wounded Marines. The exploits of all the medical department personnel bring to mind ADM Chester Nimitz's description of the Marines at Iwo Jima, when he said, "Uncommon valor was a common virtue."

Reflecting the course of the war itself, the book comes full circle. Navy medicine began its involvement taking care of Vietnamese refugees being evacuated from North Vietnam. It ends with the Navy once again evacuating fleeing refugees from Vietnam in 1975, where Navy medicine played a critical role.

In the epilogue, Herman notes that he always ended his interviews with the question, "Do you still think about Vietnam?" Virtually all responded that they've had a difficult time with their memories of their Vietnam experiences. They describe both pride and satisfaction in doing their jobs in the most difficult environment imaginable, coupled with the horror and frustration of seeing young servicemen being maimed and killed despite their efforts. Various degrees of post-traumatic stress disorder are apparent from their responses. The description of William Gerrard best described the effect that the experience in Vietnam had on many Navy medical personnel when he stated, "Vietnam is a ghost that never leaves."

In *Navy Medicine in Vietnam*, Jan Herman has produced a highly readable book that is a worthy final installment of his trilogy on U.S. Navy medicine at war. These are rare insights into war through the eyes of healthcare practitioners that will have great significance to students of military medicine. Possibly reflecting the nature of the war itself, its tone is a little darker than the previous two works, but no less compelling. Herman shows the reader Navy Medical Department men and women at their best, in a world at its very worst.

***–CAPT Lee R. Mandel, MC, Senior Medical Officer,* USS George H. W. Bush (CVN-77).**

Navy Medicine 1949

BUMED Archives

A dental officer instructs new recruits in preventive dentistry at Naval Training Center Great Lakes, IL.

In the Jan-Feb 2009 issue, the caption for A Look Back read: Dental clinic of the Regimental Hospital, 4th Marine Division, Marine Corps Expeditionary Forces, Shanghai, China.
This was in error. It should have read the 4th Marine Regiment.

DEPARTMENT OF THE NAVY
BUREAU OF MEDICINE AND SURGERY
COMMUNICATIONS DIRECTORATE
BLDG 1, RM 1217
2300 E STREET NW
WASHINGTON DC 20372-5300

Periodical
Postage and Fees Paid
USN
USPS 316-070

OFFICIAL BUSINESS